Attachment D2

Medical History

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/20xx

II. Medical History

1. In general, would you say your health is:
   - ☐ (1) Excellent
   - ☐ (2) Very good
   - ☐ (3) Good
   - ☐ (4) Fair
   - ☐ (5) Poor

2. Compared to your last visit to UB, how would you rate your health in general now?
   - ☐ (1) Much better now than at last visit
   - ☐ (2) Somewhat better now than at last visit
   - ☐ (3) About the same
   - ☐ (4) Somewhat worse now than at last visit
   - ☐ (5) Much worse now than at last visit

3. What was your weight one year ago? _____ pounds

4. How long has it been since you last saw a physician for any reason (approximately)?
   - ☐ (1) Within the last 1 year
   - ☐ (2) 1 to 3 years ago
   - ☐ (3) 3 to 5 years ago
   - ☐ (4) More than 5 years ago

5. How often do you have a routine physical examination, that is, an exam by a doctor or health care professional, not for a particular illness, but for a general checkup?
   - ☐ (1) Do not have routine physical examinations
   - ☐ (2) Less than once every five years
   - ☐ (3) At least once every five years
   - ☐ (4) At least once every year

6. Have you been told by a doctor or health care professional that you have **high blood pressure**?

☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

If **NO** or **Don't Know**, go to Question 7

A. If **YES**, how old were you when you were first told by a medical professional that you had high blood pressure?
__ __ years old. ☐ (93) Don't Know

B. For women only: If **YES**, did this condition exist only when you were pregnant?
☐ (0) No ☐ (1) Yes ☐ (3) Don't Know ☐ (8) Not Applicable

C. Are you currently being treated for high blood pressure?
☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

D. If you are being treated for high blood pressure, do you currently take:

☐ (10) Maxzide
☐ (13) Zestril
☐ (17) HCTZ
☐ (18) Atenolol
☐ (20) Accupril
☐ (21) Norvasc
☐ (24) Verapamil
☐ (27) Lisinopril
☐ (33) Diovan
☐ (44) Diovan HCT
☐ (36) Lotrel
☐ (37) Toprol, Toprol XL
☐ (47) Metoprolol
☐ (87) Other_____

7. Have you been told by a doctor or health care professional that you have **high cholesterol**?

☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

If **NO** or **Don't Know**, go to Question 8

A. If **YES**, how old were you when you were first told by a medical professional that you had high cholesterol?
__ __ years old. ☐ (93) Don't Know

B. Are you currently being treated with medication for high cholesterol?
☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

C. If you are being treated for high cholesterol, do you currently take:

☐ (1) Lipitor
☐ (10) Lovastatin
☐ (20) Crestor
☐ (22) Vytorin
☐ (24) Simvastatin
☐ (87) Other _____

8. Have you been told by a doctor or health care professional that you have **high or elevated sugar** in blood or urine?

☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

If **NO** or **Don't Know**, go to Question 9

A. If **YES**, how old were you when you were first told by a medical professional that you had elevated sugar in blood or urine?

__ __ years old. ☐ (93) Don't Know

9. Have you been told by a doctor or health care professional that you have **diabetes**?

☐ (0) No ☐ (1) Yes ☐ (3) Don't Know

If **NO** or **Don't Know**, go to Question 10

A. If **YES**, Was this
☐ (1) Insulin Dependent Diabetes (Type 1) or
☐ (2) Non-Insulin Dependent Diabetes (Type 2)

B. If **YES**, how old were you when you were first told by a medical professional that you had diabetes?

__ __ years old. ☐ (93) Don't Know

C. If **YES**, what type of treatment are you taking for your diabetes?

☐ (1) insulin injections
☐ (2) oral hypoglycemic agent (pill)
☐ (3) by dietary control
☐ (4) by exercise
☐ (5) by doing nothing
☐ (6) other

D. If you are taking an oral hypoglycemic agent (pill), for diabetes, do you currently take:

☐ (1) Glucotrol
☐ (2) Diabinese
☐ (4) Glucophage
☐ (10) Avandia
☐ (13) Metformin
☐ (16) Glyburide
☐ (17) Avandamet
☐ (87) Other _____

E. For women only: **If YES**, did this condition exist only when you were pregnant?

☐ (0) No ☐ (1) Yes ☐ (3) Don't Know ☐ (8) Not Applicable

10. If you have been told by a doctor or health care professional that you have or have had any of the listed conditions, please check "Yes" and fill in the other items. Check "No" if you have never been told that you have the condition.

	Condition	**No** (0)	**Yes** (1)	**If Yes, Age First Diagnosed**
1	**Angina** (chest pain related to your heart) If yes, was the angina confirmed by angiogram?	☐No ☐No ☐Don't Know	☐Yes ☐Yes	__ __
2	**Heart attack** (myocardial infarction, MI) Number of times this occurred _____	☐No	☐Yes	__ __
3	**Atrial fibrillation** (special type of irregular heart beat)	☐No	☐Yes	__ __
4	**Irregular heart beat** (arrhythmia)	☐No	☐Yes	__ __
5	**Diseased heart valve**	☐No	☐Yes	__ __
6	**Rheumatic heart disease**	☐No	☐Yes	__ __
7	**Congestive heart failure**	☐No	☐Yes	__ __
8	**Stroke** Number of times this occurred _____	☐No	☐Yes	__ __
9	**Transient ischemic attack** (T.I.A., "mini-stroke") Number of times this occurred _____	☐No	☐Yes	__ __
10	**Peripheral vascular disease** (intermittent claudication or leg pain on exercise, but not varicose veins)	☐No	☐Yes	__ __
11	**Deep venous thrombosis** (blood clots in your legs, but not varicose veins)	☐No	☐Yes	__ __
12	**Aortic aneurysm** (thinning in the wall of the big artery going to the heart)	☐No	☐Yes	__ __
13	**Pulmonary embolus** (blood clot in the lung)	☐No	☐Yes	__ __
14	**Childhood asthma**	☐No	☐Yes	__ __
15	**Lung problems as a child** (e.g. multiple cases of pneumonia or bronchitis) Please describe: _____	☐No	☐Yes	__ __
16	**Asthma as an adult**	☐No	☐Yes	__ __
18	**Chronic bronchitis**	☐No	☐Yes	__ __
19	**Emphysema**	☐No	☐Yes	__ __
20	**Pneumonia**	☐No	☐Yes	__ __

	Condition	No (0)	Yes (1)	If Yes, Age First Diagnosed
21	**Tuberculosis** (TB)	☐No	☐Yes	__ __
22	**Pleurisy** (inflammation of the lining of the lungs)	☐No	☐Yes	__ __
23	**Fibrotic lung disease** (Fibrosis)	☐No	☐Yes	__ __
24	**COPD** (Chronic Obstructive Pulmonary Disease)	☐No	☐Yes	__ __
25	**Other chronic lung disease**: (Please describe) _____	☐No	☐Yes	__ __
26	**Gall bladder disease**	☐No	☐Yes	__ __
27	**Kidney or bladder stones**	☐No	☐Yes	__ __
28	**Kidney disease** (Specify _____)	☐No	☐Yes	__ __
29	**Jaundiced**	☐No	☐Yes	__ __
30	**Hepatitis**	☐No	☐Yes	__ __
31	**Liver cirrhosis**	☐No	☐Yes	__ __
32	**Polyps in your colon or rectum**	☐No	☐Yes	__ __
33	**Broken bones as an adult** (includes stress fractures)	☐No	☐Yes	
	If yes, please specify which bone and age at time of fracture: **Bone:**_____ **Age:**_____ **Bone:**_____ **Age:**_____ **Bone:**_____ **Age:**_____ **Bone:**_____ **Age:**_____			
34	**Osteoporosis** (thinning bones)	☐No	☐Yes	__ __
35	**Osteoarthritis** (degenerative joint disease)	☐No	☐Yes	__ __
36	**Rheumatoid arthritis**	☐No	☐Yes	__ __
37	**Systemic lupus erythematosus** (Lupus)	☐No	☐Yes	__ __
38	**Polymyalgia**	☐No	☐Yes	__ __
39	**Sarcoidosis**	☐No	☐Yes	__ __
40	**Other immune disease**	☐No	☐Yes	__ __
41	**Thyroid disease** **Hyperthyroidism** ☐ **Hypothyroidism** ☐ **Don't Know** ☐	☐No	☐Yes	__ __
42	**Parathyroid disease**	☐No	☐Yes	__ __
43	**Seizures**	☐No	☐Yes	__ __

	Condition	No (0)	Yes (1)	If Yes, Age First Diagnosed
44	**Depression**	☐No	☐Yes	__ __
45	**Any neurologic disease**	☐No	☐Yes	__ __
46	**Benign breast disease** (non-cancerous, includes fibrocystic breast disease, fibroids, cystic breast or mastitis)	☐No	☐Yes	__ __
47	**Cancer In-Situ** (localized cancer that does not usually spread) Where:_____	☐No	☐Yes	__ __
48	**Skin cancer**	☐No	☐Yes	__ __
49	**Any other type of cancer, not skin cancer** (Please describe): _____ _____	☐No	☐Yes	__ __
50	**Are you currently undergoing treatment for cancer?** If YES, what type of treatment? Chemotherapy Radiation therapy Hormone therapy Other (Please specify_____)	☐No ☐No ☐No ☐No ☐No	☐Yes ☐Yes ☐Yes ☐Yes ☐Yes	
51	**Have you had any other disease** (Please describe): _____ _____	☐No	☐Yes	__ __

This next question deals with medical procedures which you may have had. For each item, check "Yes" if you have had the procedure, "No" if not. If you check "Yes", please write in the date of your most recent procedure.

	Procedure	No (0)	Yes (1)	Most Recent Year
1	**EKG/ECG** (electrical tracing of heart's activity)	☐No	☐Yes	_____
2	**Echocardiogram** (ultrasound of the heart and its chambers)	☐No	☐Yes	_____
3	**Stress test** (such as an exercise stress test)	☐No	☐Yes	_____
4	**Doppler test** (an ultrasound of blood vessels)	☐No	☐Yes	_____
5	**Angiogram or cardiac catheterization** (heart catheterization or coronary angiogram)	☐No	☐Yes	_____
6	**Carotid endarterectomy** (opening of blockage or narrowing of the arteries in your neck)	☐No	☐Yes	_____
7	**Clot dissolving treatment** to prevent or reduce heart attack (sometimes called TPA or streptokinase therapy)	☐No	☐Yes	_____
8	**Atherectomy** (sometimes referred to as "roto-rooter")	☐No	☐Yes	_____
9	**Angioplasty** of coronary arteries (opening arteries of the heart with a balloon- sometimes called PTCA)	☐No	☐Yes	_____
10	**Stent inserted**	☐No	☐Yes	_____
	If yes, location of stent: Coronary artery	☐No	☐Yes	_____
	Carotid artery	☐No	☐Yes	_____
11	**Heart bypass surgery** or coronary bypass surgery for blocked or clogged arteries	☐No	☐Yes	_____
12	**Heart valve repair/replacement**	☐No	☐Yes	_____
13	**Pacemaker**	☐No	☐Yes	_____
14	**Bronchoscopy** (exam of your lungs with a small scope)	☐No	☐Yes	_____
15	**Colonoscopy** (exam of your colon with a small scope)	☐No	☐Yes	_____
16	**Bone Density Test**	☐No	☐Yes	_____
17	**Chest x-ray** If yes, about how many **chest x-rays** have you had in your life: _____	☐No	☐Yes	_____
18	**X-ray of the spine or back** (to see curvature of the spine) If yes, about how many **back x-rays** have you had in your life: _____	☐No	☐Yes	_____
19	**Dental x-ray** If yes, about how many **dental x-rays** have you had in your life: _____	☐No	☐Yes	_____
20	**Other x-ray/radiation treatment** (not diagnostic) Reason_____	☐No	☐Yes	_____